

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film G586 3/2/67 mh

02140

CERTIFICATE OF DEATH

02135

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND X		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> <u>RURAL</u> <u>1 1/4 miles S.W.</u>		c. LENGTH OF STAY IN 1b <u>14</u> d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u> <u>RURAL</u> <u>22-23</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EASTERN SHORE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Wesley</u> Last <u>Brady</u>		4. DATE OF DEATH Month <u>2</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>09-14-1901</u> 9. AGE (In years last birthday) <u>65</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RURAL MAIL CARRIER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>UNKNOWN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Brady</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN MOLLIE DISHARON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>216-38-9469</u>	
17. INFORMANT Address <u>EASTERN SHORE STATE HOSPITAL (Medical Records)</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-13</u> , 19 <u>65</u> , to <u>2-23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-23</u> , 19 <u>67</u> , and that death occurred at <u>4 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>E. S. S. Hospital</u>		22b. DATE SIGNED <u>2/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Efrain C. Fernandez, M.D.</u>		22d. ADDRESS <u>E. S. S. Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2-25-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Quantico Meth. Cem</u>	23d. LOCATION (City or Town) (County) (State) <u>Quantico Wicomico Md.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Hill Funeral Home Salisbury, MD.</u> <u>Norman T. Balser</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 27 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J. [unclear]</u>

28190

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02141

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02136

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>		c. LENGTH OF STAY IN lb <u>1 yr. 1 month</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u> 19-2
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>2 Wynfall Ave.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Gertrude Evans Charwick</u>		4. DATE OF DEATH <u>2</u> Month <u>7</u> Day <u>19</u> Year <u>67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/10/85</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Thomas Evans</u>	
14. MOTHER'S MAIDEN NAME <u>Sterling (Sarah F.)</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>	
16. SOCIAL SECURITY NO. <u>217-16-9616</u>		17. INFORMANT Address <u>Medical Record Eastern Shore State Hosp</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> 9047 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia</u> DUE TO (c) <u>7 weeks</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Brain Syndrome</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in hospital</u>	
20c. TIME OF INJURY Month, Day, Year <u>12/11/66</u> Hour a.m. <u>?</u> p.m. <u>?</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Hospital</u>
20f. (City or town) <u>Cambridge</u> (County) <u>Wor.</u> (State) <u>Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN MACE JR.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>2/7/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 10, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crisfield Cemetery</u>
23d. LOCATION (City or Town) <u>Crisfield, Md.</u>		(County) (State)	
24. FUNERAL DIRECTOR <u>H. Harvey Bradshaw, Crisfield</u>		ADDRESS	
25a. REC'D BY REGISTRAR <u>FEB 15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

05190

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02142

CERTIFICATE OF DEATH

02137

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <u>Maryland</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> <u>Queen Anne</u> COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsburg, Md</u>			c. LENGTH OF STAY IN lb <u>14 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville, Maryland</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Nursing Home</u>				d. STREET ADDRESS <u>General Del., Box # 45</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Josephine Coker (also called Croker)</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>18</u> , Year <u>1967</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13, 1891</u>		9. AGE (In years last birthday) yrs. <u>75</u>	IF UNDER 1 YEAR Months <u>19</u> Days <u>19</u> Hours <u>19</u> Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Centreville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Alexander Coker</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Hard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-36-2018</u>		17. INFORMANT Address <u>Sex (Raymond Wilmer (same as above))</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>XXXXXX Malignant Lymphoma Metastasis Generalized</u> DUE TO <u>Malignant Lymphoma</u> (b) <u>2002</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>6 yrs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis Bilateral Glaucoma</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>2/17/66</u>		20f. (City or town) (County) (State) <u>2/17/67</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2/17/66</u> , 19 <u>66</u> to <u>2/17/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/17/67</u> , 19 <u>67</u> , and that death occurred at <u>10:30 PM</u> from causes and on the date stated above.							
22a. SIGNATURE <u>H. B. Plummer</u>				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. B. PLUMMER</u>				22d. ADDRESS <u>PRESTON, MARYLAND</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-21-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Centreville Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Centreville Queen Anne Md</u>	
24. FUNERAL DIRECTOR <u>Dashiell Funeral Home,</u>				ADDRESS <u>Easton, Md.</u>		25a. REC'D BY REGISTRAR OATE <u>FEB 27 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
02143					CERTIFICATE OF DEATH					02138				
1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 35 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospit al					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 200 Robbins Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First ROBERT Middle H. Last CONDON					4. DATE OF DEATH Month Feb. Day 7, Year 1967									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 1, 1897		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumberman					10b. KIND OF BUSINESS OR INDUSTRY Timber		11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME William H. Condon					14. MOTHER'S MAIDEN NAME Mamie Woollen									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. unk		17. INFORMANT Mrs. Robt. H. Condon, Cambridge, Maryland					Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE PULMONARY EMBOLI 464X DUE TO Conditions, if any, which gave rise to immediate cause (b) THROMBOPHLEBITIS LEFT LOWER LEG DUE TO underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 2-3 DAYS				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (1) (this hospital) attended the deceased from 2-6-67 , 19 67 , to 2-7-67 , 19 67 , that (1) (we) last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
22a. SIGNATURE James F. McCarter					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED 2-8-67				
22c. PHYSICIAN'S NAME (Type) JAMES F. MCCARTER, M.D.					22d. ADDRESS Box 386 Cambridge, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 9, 1967		23c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery			23d. LOCATION (City, town or county) (State) East New Market, Maryland							
24. FUNERAL DIRECTOR LeCompt e Funeral Service, Cambridge, Maryland					ADDRESS					25a. REC'D BY REGISTRAR FEB 14 1967		25b. REGISTRAR'S SIGNATURE gcharles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02144					02139						
1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> <u>DORCHESTER</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL CAMBRIDGE</u> c. LENGTH OF STAY IN 1b <u>15 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>EASTON SHORE STATE HOSPITAL</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>TALBOT</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TUNIS MILLS</u> <u>EASTON</u> <u>20-2</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>PERRY</u> <u>FORMAN</u> <u>DAFFIN</u>			4. DATE OF DEATH Month Day Year <u>FEB.</u> <u>10</u> <u>19 67</u>								
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/1/86</u>		9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>PERRY F. DAFFIN</u>					14. MOTHER'S MAIDEN NAME <u>MARTHA ELLEN Bromwell</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>-No</u>			16. SOCIAL SECURITY NO. <u>217-01-4684</u>			17. INFORMANT Address <u>HOSPITAL RECORDS</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY Abscess</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Pneumonia</u> (a), stating the underlying cause last. } DUE TO (c) <u>General debility</u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 days</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>February 4, 1967</u> to <u>February 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>February 10, 1967</u> , and that death occurred at <u>12:45 M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Carlos F. Barros</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>2-10-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>CARLOS F. BARROSO</u>					22d. ADDRESS <u>ESS Hospital Cambridge Dorchester Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-13-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Easton, Maryland</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newnam & Son Easton Md.</u>					25a. REC'D BY REGISTRAR DATE <u>FEB 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

03173

03173

100.111



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

02145

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02140

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY WOR.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CAMBRIDGE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SNOW HILL			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) EASTERN SHORE STATE HOSPITAL				d. STREET ADDRESS 23-2			
3. NAME OF DECEASED (Type or print) First JAMES Middle BEVANS Last DEVEREAUX				4. DATE OF DEATH Month FEB. Day 8 Year 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/6/83	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY TRUCK		11. BIRTHPLACE (County & State, or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOSEPH DEVEREAUX				14. MOTHER'S MAIDEN NAME HENRIETTA BEVANS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -		17. INFORMANT HOSP. RECORDS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA DUE TO (b) CEREBRAL SOFTENINGS DUE TO (c) - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/7 , 19 64 , to 2/8 , 19 67 , that (I) (we) last saw the deceased alive on 2/8 , 19 67 , and that death occurred at 10:15 from the causes and on the date stated above.							
22a. SIGNATURE <i>Relis M. Dominguez</i>				22b. DATE SIGNED 2/1/67		22c. PHYSICIAN'S NAME (Type) E.S.S.H., CAMBRIDGE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-11-67		23c. NAME OF CEMETERY OR CREMATORY Bates Memorial Meth.		23d. LOCATION (City, town or county) (State) Snow Hill Md.	
24. FUNERAL DIRECTOR <i>James E. ...</i>				25a. REC'D BY REGISTRAR FEB 10 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

05140

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02146

CERTIFICATE OF DEATH

02141

1. PLACE OF DEATH a. CDUNTY Dorchester MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. CDUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 10 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 109 Choptank Ave.,			d. STREET ADDRESS 109 Choptank Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Clarence Wesley Gibbs			4. DATE OF DEATH Month Day Year Feb. 12, 1967 19		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1900	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Photographer self employed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore	
13. FATHER'S NAME Clarence W. Gibbs			12. CITIZEN OF WHAT COUNTRY? U.S.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			14. MOTHER'S MAIDEN NAME Josephine Whitehurst		
16. SOCIAL SECURITY NO. 083-01-8089			17. INFORMANT Address Mrs. Helen K. Gibbs, Cambridge, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Hemiplegia 147X DUE TO Metastasis from Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of pyriform sinus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus - Mild					INTERVAL BETWEEN ONSET AND DEATH 1 - 2 hrs. ? 1 year +
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (1) this hospital attended the deceased from 1-24- , 19 66 , to 2-12- , 1967, that (1) was last saw the deceased alive on 2-11- , 19 67 , and that death occurred at 1:45 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Eldridge H. Wolff			22b. DATE SIGNED 2-13-67		
22c. PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M. D.			22d. ADDRESS 6 Aurora Street, Cambridge, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF Feb. 14, 1967	23c. NAME OF CEMETERY OR CREMATORY J. Wm. Lee's Sons, Inc.	23d. LOCATION (City, town or county) (State) Washington, DC.		
24. FUNERAL DIRECTOR James R. Thorne			25a. REC'D BY REGISTRAR FEB 15 1967		
ADDRESS Cambridge, Md.			25b. REGISTRAR'S SIGNATURE Charles Judge		

18180

18180

Sections of pyloric sinus

Motility from
late morning

Diabetes mellitus - Mild

5 Aurora Street, Cambridge, Mass.

Richard H. Wolff, M.D.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02147

02142

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>			
c. LENGTH OF STAY in 1b <u>2 yrs.</u>				d. STREET ADDRESS <u>—</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harrison Rest Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Elizabeth Hastings</u>				4. DATE OF DEATH Month Day Year <u>2 22 1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/25/1877</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Robert F. Lord</u>				14. MOTHER'S MAIDEN NAME <u>Mary Willoughby</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT Address <u>Mrs Elmer Hastings; Hurlock, Md</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>4201</u> (a), stating the underlying cause last. DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Mace Jr.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JOHN MACE JR.</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>2/23/67</u>			
22. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/24/67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest</u>		22d. LOCATION (City, town, or country) (State) <u>Federalburg Md</u>	
23. FUNERAL DIRECTOR <u>Ruth S. Willoughby</u>				ADDRESS <u>East New Market</u>			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>FEB 28 1967</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other person is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PAN-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

05148

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Robert F. Kennedy

Robert F. Kennedy

Robert F. Kennedy

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X

FEB 28 1961

U.S. DEPARTMENT OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02148					02143				
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b 10 Days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge-Maryland Hospital					d. STREET ADDRESS 413 Leonard's Lane			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Phillip Colecott Howard			First Middle Last		4. DATE OF DEATH Feb. 10, 1967		Month Day Year		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 16, 1895		9. AGE (In years last birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Local Hauling self employed				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) East New Market, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME J. Harry Howard					14. MOTHER'S MAIDEN NAME Minnie G. Sherman				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.		17. INFORMANT James L. Howard, Cambridge, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Urinary Bladder DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Anemia, Coronary Heart Disease, Acute Pyelonephritis.									INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Nov. '52 , 19 52 , to Feb. 10, 1967 , that (I) (we) last saw the deceased alive on Feb. 9 , 19 67 , and that death occurred at 2:40 A.M. from the causes and on the date stated above.									
22a. SIGNATURE <i>Albert E. Bunker</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-11-67		
22c. PHYSICIAN'S NAME (Type) ALBERT E. BUNKER, M. D.					22d. ADDRESS 200 Md. Ave., Cambridge, Maryland 21613				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Feb. 12, 1967		23c. NAME OF CEMETERY OR CREMATORY Lady Of Good Council Churchyard, Secretary, Md.		23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR <i>Kenneth R. Howard</i>					ADDRESS Cambridge, Md.		25a. REC'D BY REGISTRAR FEB 15 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

03133

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CERTIFICATE OF DEATH

02149

02144

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Road Snow Hill, (Rural)</u>	
c. LENGTH OF STAY IN lb <u>4 months</u>		d. STREET ADDRESS <u>Route #2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Archie J. Hutt</u>		4. DATE OF DEATH <u>2</u> Month <u>16</u> Day <u>19</u> Year <u>67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1900</u> 9. AGE (In years last birthday) <u>66</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Not listed</u>		14. MOTHER'S MAIDEN NAME <u>Not Listed</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>218-16-9312</u>	
17. INFORMANT <u>Eastern Shore State Hospital Medical Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain tumor with</u> DUE TO <u>aspiration of stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>constant</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred on _____, 19____, from causes on and on the date stated above			
22a. SIGNATURE <u>W. Rieckert</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>2-16-67</u>
22c. PHYSICIAN'S NAME (Type) <u>W. Rieckert</u>		22d. ADDRESS <u>E. New Market</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/19/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FRIENDSHIP METH.</u>	23d. LOCATION (City or Town) (County) (State) <u>Rural Snow Hill, MD.</u>
24. FUNERAL DIRECTOR <u>Gerald C. Bonds</u>		25a. REC'D BY REGISTRAR <u>Feb 20 1967</u>	
ADDRESS <u>Snow Hill, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ALSO

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02150

02145

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b 20 Years			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 300 Maryland Ave.,				d. STREET ADDRESS 300 Maryland Ave.,			
3. NAME OF DECEASED (Type or print) First Middle Last Louise Brohawn Kelly				4. DATE OF DEATH Feb. 7, 1967 19 Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Samuel M. Brohawn, Sr.,				14. MOTHER'S MAIDEN NAME Sarah Kerr			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Address Mrs. Willard Hooper, Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH Instant	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/7/67 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> John Mace, Jr. M.D. EXAMINER'S NAME (Type) John Mace, Jr. M.D. Address (Street, city, town, or county) Cambridge, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Feb. 9th. 1967		22c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery, East New Market, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR Kenneth L. Thomas, Cambridge, Md.				24a. REC'D BY REGISTRAR FEB 14 1967			
				24b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>			

24150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02151						02146					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <i>Dorchester</i>						a. STATE <i>Maryland</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>						b. COUNTY <i>Talbot</i>					
c. LENGTH OF STAY IN 1b <i>6 years</i>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Trappe</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Glasgow Nursing Home</i>						d. STREET ADDRESS					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First			Middle			Last		
			<i>Lucy</i>			<i>D</i>			<i>Kemp</i>		
4. DATE OF DEATH			Month			Day			Year		
			<i>Feb</i>			<i>23</i>			<i>1967</i>		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		IF UNDER 1 YEAR	
<i>F</i>		<i>White</i>		<i>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></i>		<i>Dec. 4, 1873</i>		<i>93 yrs.</i>		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
								<i>Talbot County America</i>			
13. FATHER'S NAME <i>Robert H. Kemp</i>						14. MOTHER'S MAIDEN NAME <i>Lavenia Newnam</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)				17. INFORMANT Address			
<i>No</i>				<i>none</i>				<i>Shirley M. Smith 311 Glenburn Ave</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease</i>											
4200 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
<i>Chronic organic brain syndrome</i>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				(City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Sept</i> , 19 <i>66</i> , to <i>Feb 23</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>Feb 20</i> , 19 <i>67</i> , and that death occurred at <i>11</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Lewis M. Burdette</i>											
22b. DATE SIGNED <i>2/23/67</i>											
22c. PHYSICIAN'S NAME (Type) <i>Lewis M. Burdette</i>											
22d. ADDRESS <i>4 Aurora St. Cambridge Md</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORY			
<i>Burial</i>				<i>2/23/67</i>				<i>Kemp Burial Lot Private</i>			
23d. LOCATION (City, town or county) (State)				23e. REC'D BY REGISTRAR				23f. REGISTRAR'S SIGNATURE			
<i>Trappe Maryland</i>				<i>DATE FEB 24 1967</i>				<i>Charles Judge</i>			
24. FUNERAL DIRECTOR ADDRESS <i>Marion Kinkannon Son Easton, Md.</i>											

08146

08146

Robert H. Kropf
F. W. H. B.
Dec 11/13 - 13
Tolbot County, N. Dak.
Larson's News
Thirteenth
1913

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/63

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02152						MEDICAL EXAMINER'S CERTIFICATE OF DEATH			02148		
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN b 30 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital						d. STREET ADDRESS Jenkins Creek Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRIETT			First FOSTER			Middle LORD			Last Feb. 11		
4. DATE OF DEATH Feb. 11			Month 19			Day 67			Year		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 29, 1889		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Chesapeake City, Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles Foster						14. MOTHER'S MAIDEN NAME unk					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. unk		17. INFORMANT Address Mrs. Robert Davis, Cambridge, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Terminal pneumonia 7048 DUE TO Fracture neck r. femur Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> Fell in National Airport 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year ? Hour a.m. 10/22/66 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Airport 20f. (City or town) (County) (State) Washington D.C.											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2/11/67 Address (Street, city, town, or county) John Mace Jr.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Feb 13 1967		22c. NAME OF CEMETERY OR CREMATORY Washington Cemetery			22d. LOCATION (City, town, or county) (State) Hurlock, Md.		
23. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland						24a. REC'D BY REGISTRAR DATE FEB 15 1967			24b. REGISTRAR'S SIGNATURE Charles Judge		

80180

80180

MEDICAL EXAMINATION CERTIFICATE

1. Name of the person examined: [illegible]
2. Date of examination: [illegible]
3. Place of examination: [illegible]
4. Name of the examining physician: [illegible]
5. Signature of the examining physician: [illegible]
6. Date of issue: [illegible]

7. Description of the condition: [illegible]
8. Date of onset: [illegible]
9. Duration of the condition: [illegible]
10. Treatment received: [illegible]
11. Date of last examination: [illegible]

12. Name of the person examined: [illegible]
13. Date of examination: [illegible]
14. Place of examination: [illegible]
15. Name of the examining physician: [illegible]
16. Signature of the examining physician: [illegible]
17. Date of issue: [illegible]

18. Description of the condition: [illegible]
19. Date of onset: [illegible]
20. Duration of the condition: [illegible]
21. Treatment received: [illegible]
22. Date of last examination: [illegible]

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/63

<div style="display: flex; justify-content: space-between;"> <div> <p>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>02153</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p> </div> <div> <p>02149</p> </div> </div>																					
1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN 1b <u>4 Years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>708 Glasgow Street</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> d. STREET ADDRESS <u>708 Glasgow Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Washington</u> Last <u>Maddox</u>			4. DATE OF DEATH Month <u>February</u> Day <u>3</u> Year <u>1967</u>																		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 20, 1891</u>		9. AGE (In years last birthday) <u>75</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.				
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Painter, Ret.</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Clanton, Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>													
13. FATHER'S NAME <u>George W. Maddox</u>					14. MOTHER'S MAIDEN NAME <u>Laura N. Foshee</u>																
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>424-01-8037</u>		17. INFORMANT Address <u>Mrs. Edward T. Budd, Bay Heights, Camb.,</u>															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last. } DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)															
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE <u>John Mace Jr.</u> EXAMINER'S NAME (Type) <u>John Mace Jr. M.D.</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2/4/67</u> <u>Cambridge, Md.</u>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 5, 1967</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parksley Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Parksley, Va.</u>															
23. FUNERAL DIRECTOR <u>Kenneth R. Thomas</u> ADDRESS <u>Shreve & Johnson Funeral Home, Parksley</u>					24a. REC'D BY REGISTRAR <u>FEB 6 1967</u>		24b. REGISTRAR'S SIGNATURE <u>f Charles Judge</u>														

Virginia

03189

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1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02154

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02150

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maine</u> b. COUNTY <u>York</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Old Orchard Beach</u> 57.3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge-Maryland Hospital</u>		d. STREET ADDRESS <u>12 Highland Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Evelyn</u> Last <u>McDuffey</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 20, 1894</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Oays Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Danville, Quebec</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Smillie</u>		14. MOTHER'S MAIDEN NAME <u>Helena Brickley</u>	
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Edward F. McDuffey</u>		12 Address <u>Highland Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage - 1143X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension Cardiovascular Disease</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>27 1/2 Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/1</u> 19 <u>67</u> to <u>2/8</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/8</u> 19 <u>67</u> , and that death occurred at <u>11</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Albert E. Bunker</u>		22b. DATE SIGNED <u>2/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Albert E. Bunker, M.D.</u>		22d. ADDRESS <u>Cambridge Md. 21613</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 11, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Josephs Benedicts</u>		23d. LOCATION (City, town or county) (State) <u>West Roxbury, Mass.</u>	
24. FUNERAL DIRECTOR <u>Kenneth R. Thomas</u>		25a. REC'D BY REGISTRAR <u>Milton Funeral Home, 1126 Washington St</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>FEB 14 1967</u>	

03150

03150



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02155					02151						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <u>Dorchester</u> MARYLAND					a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge, R.D. 2</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge-Maryland Hospital</u>					d. STREET ADDRESS <u>Route 50</u>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			Month			Day		
First <u>Bernard</u> Middle <u>Joseph</u> Last <u>McGrugan</u>			Feb. 26, 1967			19					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF FUNER 1 YEAR	
<u>Male</u>		<u>White</u>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<u>April 5, 1905</u>		<u>61</u> yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Philadelphia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Barney McGrugan</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Eastern Shore State Hospital records</u>			Address <u>Cambridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis, acute</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paroxysmal Supraventricular</u>										INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from <u>2/25/67</u> , 19 <u>67</u> , to <u>2/26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/26/67</u> 19 <u>67</u> , and that death occurred at <u>2:00</u> M., from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>										22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>										22d. ADDRESS <u>Cambridge, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Feb. 28, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>			23d. LOCATION (City, town or county) (State) <u>Cambridge, Md.</u>			
24. FUNERAL DIRECTOR <u>Emmett R. Thomas</u>					25a. REC'D BY REGISTRAR <u>[Signature]</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>MAR 2 1967</u>											

12150

12150

STATE OF NEW YORK
IN SENATE
January 10, 1907.

REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
JANUARY 10, 1907.

ALBANY:
J. B. LEECH, JR.,
PRINTERS.
1907.

MADE BY THE
COMMISSIONER OF THE LAND OFFICE
JANUARY 10, 1907.

02156

CERTIFICATE OF DEATH

02152

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY Q.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CAMBRIDGE		c. LENGTH OF STAY IN 1b 3 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE Edward MCLAUGHLIN		4. DATE OF DEATH Month FEB. Day 27 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/24/60
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN BELL MCLAUGHLIN		14. MOTHER'S MAIDEN NAME AMANDA MEREDITH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) - No		16. SOCIAL SECURITY NO. 220-32-9564	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Chronic bronchitis and emphysema			INTERVAL BETWEEN ONSET AND DEATH Few minutes 5 years 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/14 , 19 64 , to 2/27 , 19 67 , that (I) (we) last saw the deceased alive on 2/27 , 19 67 , and that death occurred at 8:25 M, from causes and on the date stated above.			
22a. SIGNATURE Carlos F Barroso		22b. DATE SIGNED 2/27/67	
22c. PHYSICIAN'S NAME (Type) CARLOS F. BARROSO, M.D.		22d. ADDRESS E.S.S. HOSPITAL, CAMBRIDGE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MAR 1, 1967	23c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery	23d. LOCATION (City or Town) (County) (State) Centerville Q.A.Co. Md.
24. FUNERAL DIRECTOR James H. Bata Jr. Bata Bros. Centerville, Md 21617		25a. RECEIVED BY REGISTRAR MAR 2 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07150

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02157

CERTIFICATE OF DEATH

02153

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge- Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital, Inc.		d. STREET ADDRESS R.F.D. # 2	
3. NAME OF DECEASED (Type or print) First Middle Last Delancy P. Molock		4. DATE OF DEATH Month Day Year February 15, 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 11, 1890
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Pinder		14. MOTHER'S MAIDEN NAME Ella Wilson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No -----		16. SOCIAL SECURITY NO. 219-07-7249 A	
17. INFORMANT Olis Molock		Address Star Route Vienna, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4201 (c) -----		INTERVAL BETWEEN ONSET AND DEATH 5 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 7, 19 67 , to Feb 15, 19 67 that (I) (we) last saw the deceased alive on Feb 15, 19 67 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE J. Edwin Fassett		22b. DATE SIGNED 2/17/67	
22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.		22d. ADDRESS 623 High Street Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/18/67	
23c. NAME OF CEMETERY OR CREMATORY Fork Neck		23d. LOCATION (City or Town) (County) (State) Dorchester Co., Md.	
24. FUNERAL DIRECTOR Julius C. [Signature]		25a. REC'D BY REGISTRAR Feb 20 1967	
ADDRESS Cambridge, Md.		25b. REGISTRAR'S SIGNATURE [Signature]	

05153

RECEIVED

1966

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a memorandum or report.]

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1302

VR A15ME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02158

02154

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Madison	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital		d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) J. DARCY MOORE		4. DATE OF DEATH Feb. 13, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 28, 1914
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman-Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Camb. Wire Cloth	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Moore		14. MOTHER'S MAIDEN NAME Sadie Cox	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unk	
17. INFORMANT Mrs. J. Darcy Moore, Madison, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 4301 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Instant			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour s.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2/13/67 Address (Street, city, town, or county) Cambridge, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 15, 1967	
22c. NAME OF CEMETERY OR CREMATORY Joppa Methodist Churchyard		22d. LOCATION (City, town, or county) (State) Madison, Maryland	
23. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		24a. REC'D BY REGISTRAR FEB 15 1967	
24b. REGISTRAR'S SIGNATURE J Charles Judge			

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RECORDS MANAGEMENT DIVISION OF FBI

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1 (M)
FOR STATE
HEALTH DEPT.

02159

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02155

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural		c. LENGTH OF STAY IN lb 40 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hynson		d. STREET ADDRESS Hynson	
3. NAME OF DECEASED (Type or print) First Middle Last Joshua Samuel Nichols		4. DATE OF DEATH Month Day Year February 4 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1912
9. AGE (In years lost birthday) yrs. 54		IF UNDER 1 Year Months Days Hours Min. 4 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Factory	
11. BIRTHPLACE (State or foreign country) Oxford, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Nichols		14. MOTHER'S MAIDEN NAME Lizzie (maiden name unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-12-6180	
17. INFORMANT Records of Pine Bluff Hospital, Salisbury, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism with 5271 DUE TO bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Peter W. Rieckert M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Peter W. Rieckert E-New Market, Md.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> 2-6-67 22. DATE SIGNED	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, City, Town or County)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 9, 1967	23c. NAME OF CEMETERY OR CREMATORY Rhodesdale Cemetery	23d. LOCATION (City or Town) (County) (State) Near Rhodesdale, Maryland
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Maryland		25a. REC'D BY REGISTRAR FEB 14 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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03130

03130

[Faint, illegible text throughout the page, likely bleed-through from the reverse side. Some fragments are visible, such as "The following information was obtained from the records of the Department of the Interior, Bureau of Land Management, Washington, D.C." and "The following information was obtained from the records of the Department of the Interior, Bureau of Land Management, Washington, D.C."]

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02160

CERTIFICATE OF DEATH

02156

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN <u>ib</u> <u>5 mos</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u> 19-2		d. STREET ADDRESS <u>W. 1st Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mannie H. Riggins</u>		4. DATE OF DEATH Month <u>2</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-22-1876</u> 9. AGE (In years lost birthday) <u>91</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Herbert</u>		14. MOTHER'S MAIDEN NAME <u>DIANNA Harney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-54-9712</u>	
17. INFORMANT <u>Records - E. S. S. Hosp.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>-</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-5</u> , 19 <u>66</u> to <u>2-17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-17</u> , 19 <u>67</u> , and that death occurred at <u>2:13</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Felipe M. Dominguez, M.D.</u>		22b. DATE SIGNED <u>2-17-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FELIPE M. DOMINGUEZ, M.D.</u>		22d. ADDRESS <u>E.S.S.H.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 20, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunnyridge Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Crisfield, Md.</u>
24. FUNERAL DIRECTOR <u>H. Harvey Bradshaw</u>		25a. REC'D BY REGISTRAR <u>20 1967</u>	
ADDRESS <u>Crisfield, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Felipe M. Dominguez</u>	

05150

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

02161

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02157

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 10 hrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 215 Willis Street			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Andrews d. STREET ADDRESS None e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ALEXANDER Middle G. Last ROBBINS			4. DATE OF DEATH Month Feb. Day 1 Year 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1896	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 09 Days 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist-Retired		10b. KIND OF BUSINESS OR INDUSTRY Nat'l Can Co.	11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Alexander G. Robbins			14. MOTHER'S MAIDEN NAME Vertie Shorter		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1 214-10-8866A	17. INFORMANT Address Mr. Vernon Robbins, Cambridge, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH Abt. 8hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D. 2/2/67 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Cambridge, Md. Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 6, 1967	22c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR ADDRESS LeCompte Funeral Service, Cambridge, Maryland			24a. REC'D BY REGISTRAR FEB 3 1967 24b. REGISTRAR'S SIGNATURE f. Charles Judge		

MEDICAL CERTIFICATION

02151

02151

JUL 25, 1952

OFFICE OF THE

JOHN W. BAKER

ALEXANDER L. BAKER

21-11-1952

JOHN W. BAKER

John W. Baker

JOHN W. BAKER

JOHN W. BAKER

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02162

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02159

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna - Rural			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna - Rural 09-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Vienna - Rhodesdale Road				d. STREET ADDRESS Vienna - Rhodesdale Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Constance Middle Dianne Last Sterling				4. DATE OF DEATH Month February Day 16 Year 1967			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH Sept. 21, 1966	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Vienna, Md., RFD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leroy Jackson				14. MOTHER'S MAIDEN NAME Darlene Sterling			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Leroy Jackson, Vienna, Md., RFD Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia DUE TO Acute respiratory infection (S.D.I.I.) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Instant						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Mace Jr. EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 17, 1967		23c. NAME OF CEMETERY OR CREMATORY Rhodesdale Cemetery		23d. LOCATION (City or Town) (County) (State) Rhodesdale, Maryland, RFD	
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalburg, Maryland ADDRESS				25a. RECEIVED BY REGISTRAR 1967 DATE FEB 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

05128

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02163

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02160

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Honga d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) None		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Honga d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) LEO HOWARD TOLLEY		4. DATE OF DEATH Month Feb. Day 12 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 11, 1894
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days 	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (State or foreign country) Honga, Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Samuel H. Tolley		14. MOTHER'S MAIDEN NAME Cora Ruark	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-16-9988	
17. INFORMANT Address Mrs. Leo H. Tolley, Honga, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, lecture, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 2/13/67 DATE SIGNED Cambridge, Md.	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb 15, 1967	22c. NAME OF CEMETERY OR CREMATORY Hosier Memorial Cemetery	22d. LOCATION (City, town, or county) (State) Fishing Creek, Maryland
23. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		24a. REC'D BY REGISTRAR FEB 15 1967 24b. REGISTRAR'S SIGNATURE Charles Judge	

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02164

CERTIFICATE OF DEATH

02161

1. PLACE OF DEATH o. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MD. b. COUNTY DOR.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CAMBRIDGE		c. LENGTH OF STAY IN lb 7 WEEKS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HERBERT C. TYLER		4. DATE OF DEATH Month FEB. Day 27 Year 19 67.	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/9/86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY Seafood	9. AGE (In years lost birthday) 81 yrs.
11. BIRTHPLACE (County & State, or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jabez Tyler		14. MOTHER'S MAIDEN NAME EMILY GOOTTEE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 493X IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) General debility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 days 1 year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/5 , 19 67 , to 2/27 , 19 67 , that (I) (we) last saw the deceased alive on 2/27 19 67 , and that death occurred at 12:40 M, from causes and on the date stated above.			
22a. SIGNATURE Carlos F. Barros		22b. DATE SIGNED 2/27/67	
22c. PHYSICIAN'S NAME (Type) CARLOS F. BARROSO		22d. ADDRESS E.S. SH., CAMBRIDGE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Mar 2, 1967	23c. NAME OF CEMETERY OR CREMATORY Hosier Memorial Churchyard	23d. LOCATION (City or Town) (County) (State) Fishing Creek, Md.
24. FUNERAL DIRECTOR LECOMPTE FUNERAL SERVICE		25a. REC'D BY REGISTRAR DATE MAR 3 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10180

CONFIRMATION OF DEATH

10180

Name of Deceased		Date of Death	
Place of Death		Cause of Death	
Age at Death		Sex	
Marital Status		Occupation	
Education		Religion	
Last Residence		Previous Residence	
Social Security Number		Date of Birth	
Signature of Informant		Signature of Doctor	
Date of Report		Date of Death	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
02165						CERTIFICATE OF DEATH			02162				
1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 10 weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Church Creek d. STREET ADDRESS None e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) HOWARD E. WALLACE						4. DATE OF DEATH Feb. 20, 1967							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 17, 1893		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Lorenzo Wallace						14. MOTHER'S MAIDEN NAME Della Meekins							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. unk		17. INFORMANT Mrs. Howard E. Wallace, Church Creek, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF PROSTATE WITH METASTASIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 11-19-62 , 19 62 , to 2020-60 , that (I) (we) last saw the deceased alive on 2-20-67 , 19 67 , and that death occurred at 9:30 PM from the causes and on the date stated above.													
22a. SIGNATURE Albert E. Bunker						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-22-67					
22c. PHYSICIAN'S NAME (Type) ALBERT E. BUNKER, M. D.						22d. ADDRESS 200 Md. Ave., Cambridge, Maryland 21613							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 23 1967		23c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery				23d. LOCATION (City, town or county) (State) East New Market, Maryland					
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland						25a. REC'D BY REGISTRAR FEB 24 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge					

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02166

CERTIFICATE OF DEATH

02163

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>		c. LENGTH OF STAY IN TB <u>24.9 Wks.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		20-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hosp.</u>				d. STREET ADDRESS <u>306 South Aurora St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Virginia</u> First Middle Last				4. DATE OF DEATH <u>Feb. 1</u> 19 <u>67</u> Month Day Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>6-18-80</u>		9. AGE (In years last birthday) yrs. <u>86</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Tucker</u>				14. MOTHER'S MAIDEN NAME <u>Anna Karen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-34-56230L</u>		17. INFORMANT <u>Records - Hospital</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>general debility</u> DUE TO (c) <u>arteriosclerosis, generalized</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Wks</u> <u>Yrs</u> <u>Yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Aug 7</u> , 19 <u>54</u> , to <u>Feb 1</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Feb 1</u> , 19 <u>67</u> , and that death occurred at <u>4:25 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>John B. Webster</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>1 Feb 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John B. Webster</u>				22d. ADDRESS <u>Eastern Shore State Hosp.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/4/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CHURCH HILL</u>		23d. LOCATION (City or Town) (County) (State) <u>CHURCH HILL, MD.</u>	
24. FUNERAL DIRECTOR <u>Maurice E. Newman-Son</u>				ADDRESS <u>Easton, Md</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 2 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If permitted, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05183

CERTIFICATE OF BIRTH

05183

NAME OF CHILD		DATE OF BIRTH		PLACE OF BIRTH	
FATHER'S NAME		MOTHER'S NAME			
FATHER'S RESIDENCE		MOTHER'S RESIDENCE			
FATHER'S OCCUPATION		MOTHER'S OCCUPATION			
FATHER'S SIGNATURE		MOTHER'S SIGNATURE			
FATHER'S ADDRESS		MOTHER'S ADDRESS			
FATHER'S TELEPHONE		MOTHER'S TELEPHONE			
FATHER'S SOCIAL SECURITY		MOTHER'S SOCIAL SECURITY			
FATHER'S MARITAL STATUS		MOTHER'S MARITAL STATUS			
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH			
FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH			
FATHER'S RACE		MOTHER'S RACE			
FATHER'S RELIGION		MOTHER'S RELIGION			
FATHER'S EDUCATION		MOTHER'S EDUCATION			
FATHER'S EMPLOYMENT		MOTHER'S EMPLOYMENT			
FATHER'S INCOME		MOTHER'S INCOME			
FATHER'S HEALTH		MOTHER'S HEALTH			
FATHER'S MENTAL		MOTHER'S MENTAL			
FATHER'S PHYSICAL		MOTHER'S PHYSICAL			
FATHER'S SEXUAL		MOTHER'S SEXUAL			
FATHER'S REPRODUCTIVE		MOTHER'S REPRODUCTIVE			
FATHER'S GENETIC		MOTHER'S GENETIC			
FATHER'S IMMUNE		MOTHER'S IMMUNE			
FATHER'S METABOLIC		MOTHER'S METABOLIC			
FATHER'S ENDOCRINE		MOTHER'S ENDOCRINE			
FATHER'S NERVOUS		MOTHER'S NERVOUS			
FATHER'S MUSCULAR		MOTHER'S MUSCULAR			
FATHER'S SKELETAL		MOTHER'S SKELETAL			
FATHER'S DERMATOLOGICAL		MOTHER'S DERMATOLOGICAL			
FATHER'S OPHTHALMOLOGICAL		MOTHER'S OPHTHALMOLOGICAL			
FATHER'S OTOLARYNGOLOGICAL		MOTHER'S OTOLARYNGOLOGICAL			
FATHER'S RADIOLOGICAL		MOTHER'S RADIOLOGICAL			
FATHER'S PATHOLOGICAL		MOTHER'S PATHOLOGICAL			
FATHER'S NEUROLOGICAL		MOTHER'S NEUROLOGICAL			
FATHER'S PSYCHIATRIC		MOTHER'S PSYCHIATRIC			
FATHER'S GYNECOLOGICAL		MOTHER'S GYNECOLOGICAL			
FATHER'S PEDIATRIC		MOTHER'S PEDIATRIC			
FATHER'S GERIATRIC		MOTHER'S GERIATRIC			
FATHER'S ONCOLOGICAL		MOTHER'S ONCOLOGICAL			
FATHER'S CARDIOLOGICAL		MOTHER'S CARDIOLOGICAL			
FATHER'S RESPIROLOGICAL		MOTHER'S RESPIROLOGICAL			
FATHER'S GASTROENTEROLOGICAL		MOTHER'S GASTROENTEROLOGICAL			
FATHER'S HEPATOLOGICAL		MOTHER'S HEPATOLOGICAL			
FATHER'S RENAL		MOTHER'S RENAL			
FATHER'S UROLOGICAL		MOTHER'S UROLOGICAL			
FATHER'S ENDOCRINOLOGICAL		MOTHER'S ENDOCRINOLOGICAL			
FATHER'S IMMUNOLOGICAL		MOTHER'S IMMUNOLOGICAL			
FATHER'S MICROBIOLOGICAL		MOTHER'S MICROBIOLOGICAL			
FATHER'S PARASITOLOGICAL		MOTHER'S PARASITOLOGICAL			
FATHER'S ZOOTOLOGICAL		MOTHER'S ZOOTOLOGICAL			
FATHER'S BOTANICAL		MOTHER'S BOTANICAL			
FATHER'S AGRICULTURAL		MOTHER'S AGRICULTURAL			
FATHER'S VETERINARY		MOTHER'S VETERINARY			
FATHER'S FISHERY		MOTHER'S FISHERY			
FATHER'S FORESTRY		MOTHER'S FORESTRY			
FATHER'S MINING		MOTHER'S MINING			
FATHER'S CONSTRUCTION		MOTHER'S CONSTRUCTION			
FATHER'S MANUFACTURING		MOTHER'S MANUFACTURING			
FATHER'S TRANSPORTATION		MOTHER'S TRANSPORTATION			
FATHER'S COMMUNICATIONS		MOTHER'S COMMUNICATIONS			
FATHER'S EDUCATION		MOTHER'S EDUCATION			
FATHER'S RESEARCH		MOTHER'S RESEARCH			
FATHER'S ARTS		MOTHER'S ARTS			
FATHER'S LITERATURE		MOTHER'S LITERATURE			
FATHER'S MUSIC		MOTHER'S MUSIC			
FATHER'S THEATRE		MOTHER'S THEATRE			
FATHER'S FILM		MOTHER'S FILM			
FATHER'S TELEVISION		MOTHER'S TELEVISION			
FATHER'S RADIO		MOTHER'S RADIO			
FATHER'S JOURNALISM		MOTHER'S JOURNALISM			
FATHER'S PUBLIC RELATIONS		MOTHER'S PUBLIC RELATIONS			
FATHER'S MARKETING		MOTHER'S MARKETING			
FATHER'S SALES		MOTHER'S SALES			
FATHER'S MANAGEMENT		MOTHER'S MANAGEMENT			
FATHER'S ACCOUNTING		MOTHER'S ACCOUNTING			
FATHER'S FINANCE		MOTHER'S FINANCE			
FATHER'S INVESTMENT		MOTHER'S INVESTMENT			
FATHER'S REAL ESTATE		MOTHER'S REAL ESTATE			
FATHER'S LEGAL		MOTHER'S LEGAL			
FATHER'S MEDICAL		MOTHER'S MEDICAL			
FATHER'S DENTAL		MOTHER'S DENTAL			
FATHER'S VETERINARY		MOTHER'S VETERINARY			
FATHER'S AGRICULTURAL		MOTHER'S AGRICULTURAL			
FATHER'S FORESTRY		MOTHER'S FORESTRY			
FATHER'S MINING		MOTHER'S MINING			
FATHER'S CONSTRUCTION		MOTHER'S CONSTRUCTION			
FATHER'S MANUFACTURING		MOTHER'S MANUFACTURING			
FATHER'S TRANSPORTATION		MOTHER'S TRANSPORTATION			
FATHER'S COMMUNICATIONS		MOTHER'S COMMUNICATIONS			
FATHER'S EDUCATION		MOTHER'S EDUCATION			
FATHER'S RESEARCH		MOTHER'S RESEARCH			
FATHER'S ARTS		MOTHER'S ARTS			
FATHER'S LITERATURE		MOTHER'S LITERATURE			
FATHER'S MUSIC		MOTHER'S MUSIC			
FATHER'S THEATRE		MOTHER'S THEATRE			
FATHER'S FILM		MOTHER'S FILM			
FATHER'S TELEVISION		MOTHER'S TELEVISION			
FATHER'S RADIO		MOTHER'S RADIO			
FATHER'S JOURNALISM		MOTHER'S JOURNALISM			
FATHER'S PUBLIC RELATIONS		MOTHER'S PUBLIC RELATIONS			
FATHER'S MARKETING		MOTHER'S MARKETING			
FATHER'S SALES		MOTHER'S SALES			
FATHER'S MANAGEMENT		MOTHER'S MANAGEMENT			
FATHER'S ACCOUNTING		MOTHER'S ACCOUNTING			
FATHER'S FINANCE		MOTHER'S FINANCE			
FATHER'S INVESTMENT		MOTHER'S INVESTMENT			
FATHER'S REAL ESTATE		MOTHER'S REAL ESTATE			
FATHER'S LEGAL		MOTHER'S LEGAL			
FATHER'S MEDICAL		MOTHER'S MEDICAL			
FATHER'S DENTAL		MOTHER'S DENTAL			
FATHER'S VETERINARY		MOTHER'S VETERINARY			
FATHER'S AGRICULTURAL		MOTHER'S AGRICULTURAL			
FATHER'S FORESTRY		MOTHER'S FORESTRY			
FATHER'S MINING		MOTHER'S MINING			
FATHER'S CONSTRUCTION		MOTHER'S CONSTRUCTION			
FATHER'S MANUFACTURING		MOTHER'S MANUFACTURING			
FATHER'S TRANSPORTATION		MOTHER'S TRANSPORTATION			
FATHER'S COMMUNICATIONS		MOTHER'S COMMUNICATIONS			
FATHER'S EDUCATION		MOTHER'S EDUCATION			
FATHER'S RESEARCH		MOTHER'S RESEARCH			
FATHER'S ARTS		MOTHER'S ARTS			
FATHER'S LITERATURE		MOTHER'S LITERATURE			
FATHER'S MUSIC		MOTHER'S MUSIC			
FATHER'S THEATRE		MOTHER'S THEATRE			
FATHER'S FILM		MOTHER'S FILM			
FATHER'S TELEVISION		MOTHER'S TELEVISION			
FATHER'S RADIO		MOTHER'S RADIO			
FATHER'S JOURNALISM		MOTHER'S JOURNALISM			
FATHER'S PUBLIC RELATIONS		MOTHER'S PUBLIC RELATIONS			
FATHER'S MARKETING		MOTHER'S MARKETING			
FATHER'S SALES		MOTHER'S SALES			
FATHER'S MANAGEMENT		MOTHER'S MANAGEMENT			
FATHER'S ACCOUNTING		MOTHER'S ACCOUNTING			
FATHER'S FINANCE		MOTHER'S FINANCE			
FATHER'S INVESTMENT		MOTHER'S INVESTMENT			
FATHER'S REAL ESTATE		MOTHER'S REAL ESTATE			
FATHER'S LEGAL		MOTHER'S LEGAL			
FATHER'S MEDICAL		MOTHER'S MEDICAL			
FATHER'S DENTAL		MOTHER'S DENTAL			
FATHER'S VETERINARY		MOTHER'S VETERINARY			
FATHER'S AGRICULTURAL		MOTHER'S AGRICULTURAL			
FATHER'S FORESTRY		MOTHER'S FORESTRY			
FATHER'S MINING		MOTHER'S MINING			
FATHER'S CONSTRUCTION		MOTHER'S CONSTRUCTION			
FATHER'S MANUFACTURING		MOTHER'S MANUFACTURING			
FATHER'S TRANSPORTATION		MOTHER'S TRANSPORTATION			
FATHER'S COMMUNICATIONS		MOTHER'S COMMUNICATIONS			
FATHER'S EDUCATION		MOTHER'S EDUCATION			
FATHER'S RESEARCH		MOTHER'S RESEARCH			
FATHER'S ARTS		MOTHER'S ARTS			
FATHER'S LITERATURE		MOTHER'S LITERATURE			
FATHER'S MUSIC		MOTHER'S MUSIC			
FATHER'S THEATRE		MOTHER'S THEATRE			
FATHER'S FILM		MOTHER'S FILM			
FATHER'S TELEVISION		MOTHER'S TELEVISION			
FATHER'S RADIO		MOTHER'S RADIO			
FATHER'S JOURNALISM		MOTHER'S JOURNALISM			
FATHER'S PUBLIC RELATIONS		MOTHER'S PUBLIC RELATIONS			
FATHER'S MARKETING		MOTHER'S MARKETING			
FATHER'S SALES		MOTHER'S SALES			
FATHER'S MANAGEMENT		MOTHER'S MANAGEMENT			
FATHER'S ACCOUNTING		MOTHER'S ACCOUNTING			
FATHER'S FINANCE		MOTHER'S FINANCE			
FATHER'S INVESTMENT		MOTHER'S INVESTMENT			
FATHER'S REAL ESTATE		MOTHER'S REAL ESTATE			
FATHER'S LEGAL		MOTHER'S LEGAL			
FATHER'S MEDICAL		MOTHER'S MEDICAL			
FATHER'S DENTAL		MOTHER'S DENTAL			
FATHER'S VETERINARY		MOTHER'S VETERINARY			
FATHER'S AGRICULTURAL		MOTHER'S AGRICULTURAL			
FATHER'S FORESTRY		MOTHER'S FORESTRY			
FATHER'S MINING		MOTHER'S MINING			

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02167

CERTIFICATE OF DEATH

03562

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cambridge 09-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital, Inc.		d. STREET ADDRESS Aireys- Route # 2	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Lillie Middle Chase Last Wheatley		4. DATE OF DEATH February 21, 1967	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 29, 1896
9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Moses Chase	
14. MOTHER'S MAIDEN NAME Mary Elizabeth Stanley		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No -----	
16. SOCIAL SECURITY NO. 220-03-5669A		17. INFORMANT Elsie Brown Rt. #2 Cambridge, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 442X IMMEDIATE CAUSE (a) Cardiac Decompensation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Hypertensive Arteriosclerotic Cardio- DUE TO vascular Renal Disease (c) -----		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 27, 1966 to Feb. 21, 1967 that (I) (we) lost saw the deceased alive on Feb. 21, 1967 , and that death occurred at ----- M, from causes and on the date stated above.			
22a. SIGNATURE J. Edwin Fassett		22b. DATE SIGNED 2-21-67	
22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.		22d. ADDRESS 623 High Street Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/26/67	
23c. NAME OF CEMETERY OR CREMATORY Salem		23d. LOCATION (City or Town) (County) (State) Dorchester Co. Md.	
24. FUNERAL DIRECTOR John C. Davis		25a. REC'D BY REGISTRAR MAR 8 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S NAME Charles Judge	

03113

03263

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]

4. Date of birth: [illegible]
5. Place of birth: [illegible]

6. Date of death: [illegible]
7. Place of death: [illegible]

8. Cause of death: [illegible]
9. Manner of death: [illegible]

10. Signature of physician: [illegible]
11. Signature of registrar: [illegible]

12. Date of registration: [illegible]
13. Place of registration: [illegible]

14. Signature of registrar: [illegible]
15. Signature of physician: [illegible]

16. Date of registration: [illegible]
17. Place of registration: [illegible]

18. Signature of registrar: [illegible]
19. Signature of physician: [illegible]

20. Date of registration: [illegible]
21. Place of registration: [illegible]

22. Signature of registrar: [illegible]
23. Signature of physician: [illegible]

24. Date of registration: [illegible]
25. Place of registration: [illegible]

26. Signature of registrar: [illegible]
27. Signature of physician: [illegible]

28. Date of registration: [illegible]
29. Place of registration: [illegible]

30. Signature of registrar: [illegible]
31. Signature of physician: [illegible]

32. Date of registration: [illegible]
33. Place of registration: [illegible]

34. Signature of registrar: [illegible]
35. Signature of physician: [illegible]

36. Date of registration: [illegible]
37. Place of registration: [illegible]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02168 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02164											
1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>20 Hours</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> <u>Madison</u>				09-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge-Maryland Hospital</u>						d. STREET ADDRESS <u>Rural</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Ivy</u> Middle <u>Floyd</u> Last <u>Woolford</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>14</u> Year <u>1967</u>			5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Jan. 18, 1893</u>			9. AGE (In years last birthday) <u>74</u> yrs.			IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u>		IF UNDER 24 HRS. Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Madison</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		
13. FATHER'S NAME <u>Asbury H. Woolford</u>						14. MOTHER'S MAIDEN NAME <u>Lavenia Tall</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-46-3879</u>		17. INFORMANT Address <u>Mrs. Lillian Foxwell, Madison, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive myocardial infarct</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary occlusion</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S SIGNATURE <u>B. W. Rieckert</u> M.D. NAME (Type) <u>B. W. Rieckert</u> E-New Market, Md. Address (Street, city, town, or county) DATE SIGNED <u>2-14-67</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 16, 1967</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Old Trinity Churchyard</u>		22d. LOCATION (City, town, or county) <u>Church Creek, Md.</u>		(State)			
23. FUNERAL DIRECTOR <u>R. H. Thomas</u> ADDRESS <u>Cambridge, Md.</u>						24a. REC'D BY REGISTRAR <u>FEB 16 1967</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

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overlapped

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02169					02165				
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge			c. LENGTH OF STAY IN 1b 2 Months		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge, R.D. 2 & Rt. 50 09-1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge-Maryland Hospital					d. STREET ADDRESS Rural			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Thomas Wootten			4. DATE OF DEATH Month Day Year Feb. 23, 1967 19						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 14, 1905		9. AGE (In years last birthday) 61 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) State Hospital Attendant				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Frankfort, Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James S. Wootten					14. MOTHER'S MAIDEN NAME Amanda Foskey				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mrs. Evelyn B. Wootten, Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X Careman of Prostate DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at 2:00 P.M. from the causes and on the date stated above.									
22a. SIGNATURE E.C.H. Schmidt				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) E.C.H. Schmidt				22d. ADDRESS Cambridge, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 26, 1967		23c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery		23d. LOCATION (City, town or county) (State) East New Market, Md.			
24. FUNERAL DIRECTOR Kenneth D. Thomas				ADDRESS Cambridge, Md.		25a. REC'D BY REGISTRAR DATE MAR 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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